MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH RADIATION CONTROL PROGRAM

MAMMOGRAPHY MACHINE IDENTIFICATION FORM

FACILITY NAME:			
MASSACHUSETTS MAMMOGRAPHY LICENSE NUMBER: M			
MAMMOGR	APHY MACHINE INFORMATION: (CHECK	THE APPROPRIATE ITEMS)	
1.	THIS IS A BRAND NEW MAMMOGRAPH THE MAMMOGRAPHY MACHINE HAS		
2. UNIT MANUFACTURER:			
3. UNIT MODEL:			
4. DATE OF MANUFACTURE (MONTH AND YEAR);			
5. SERIAL NUMBER:			
6. DATE OF	INSTALLATION:	□ PLANNED □ ACTUAL	
7. DATE THAT YOU PLAN ON USING THE UNIT TO IMAGE PATIENTS:			
8. DATE ACCREDITATION MATERIAL SUBMITTED TO ACR:			
9. PLEASE INDICATE (CHECK ALL THAT ARE APPROPRIATE) HOW THIS X-RAY UNIT IS TO BE USED FOR BREAST DISEASE DETECTION OR SURGICAL PROCEDURES AT YOUR FACILITY:			
□ SCRI	EENING ONLY	□ STEREOTACTIC	
□ DIAC	GNOSTIC ONLY	□ SPECIMEN	
□ DIAC	GNOSTIC & SCREENING	☐ RESEARCH EQUIPMENT	
□ STOI	RED (INACTIVE)	□ CABINET X-RAY	
□ NEEI	OLE LOCALIZATION	□ OTHER (SPECIFY)	

10. MACHINE SU	
11. MACHINE INS	STALLER: (CHECK IF SAME AS SUPPLIER)
ADDRESS:	
	ENT:
13. FACILITY MA	MMOGRAPHY UNIT STATUS: (CHECK ALL APPROPRIATE ITEMS)
	THIS MAMMOGRAPHY UNIT IS AN ADDITIONAL UNIT.
	THIS MAMOGRAPHY UNIT REPLACES THE (SPECIFY THE MANUFACTURER AND MODEL):
	THE REPLACED MAMMOGRAPHY UNIT:
	$\hfill \square$ WILL BE STORED AT OUR FACILITY, BUT NOT USED.
	☐ IS BEING RELOCATED TO ANOTHER FACILITY (SPECIFY THE LICENSED FACILITY NAME AND "M" NUMBER)
	☐ HAS BEEN TRADED IN TO: (SPECIFY)
	□ OTHER:
PERSON COMPLI	ETING THIS FORM: (PLEASE PRINT)
NAME:	
DATE:	
	NE NUMBER:
FAX NUMI	BER: